IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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January 12, 2009

Michael Dempsey
Family Home Health
2950 East Magic View Drive, Suite 192
Meridian, Idaho 83642

Provider #137079

Dear Mr. Dempsey:

On **December 30, 2008**, a complaint survey was conducted at Family Home Health. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003828

Allegation #1: The agency nurses did not provide a through assessment of patient needs to include a review of patient's medications.

Findings: An unannounced visit was made at the agency on 12/29/08 thru 12/30/08. Five clinical records, policies and procedures, complaint and grievances were reviewed. Observations of staff and patient's were made and patients', staff and physicians' were interviewed.

One patient's record documented a 67 year-old female who was admitted to the agency on 9/30/08, following a left total knee revision. Review of the initial comprehensive assessment, which was conducted by the registered nurse, revealed the following responses to listed assessment items:

a.) Patient lives with: Lives alone.
b.) Primary Caregiver: No one person.
c.) Ability to Dress Upper Body: Able to dress upper body without assistance if clothing is laid out or handed to the patient.

d.) Ability to Dress Lower Body: Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
e.) Bathing: Able to bathe in shower or tub with the assistance of another person to get in and out of the shower or tub.
f.) Transferring: Transfers with minimal human assistance or with use of an assistive devise.
g.) Feeding or eating: Able to feed self independently but requires meal set up.
h.) Planning and preparing light meals: Unable to prepare any light meals or reheat any delivered meals.
i.) Laundry: Unable to do any laundry due to physical limitation.
j.) Housekeeping: Unable to effectively participate in any housekeeping tasks.
k.) Shopping: Unable to go shopping.

The initial comprehensive assessment did not state who would provide the above needs or how the above needs would be met. A "PATIENT COMPLAINT/PROBLEM RESOLUTION REPORT", dated 10/13/08, stated that the patient had not received HHA (Home Health Aide) services 2-4 hrs (Hours) per day per the patient's request. The nurse who did the patient's initial comprehensive assessment was interviewed. He stated the patient thought the agency was there to "clean her house". He said he thought the patient had a boyfriend who was bathing and dressing the patient and a 10-year-old grandson to do errands. He stated the patient did not request additional services at the time of the comprehensive assessment but did not document this information.

It was determined the agency failed to ensure that initial comprehensive assessment had thoroughly described the health care status needs and how those needs were being met for the patient.

Additionally, the patient's medication orders were reviewed. The patient's record contained a list of medications titled, "(Hospitals name) Admission and Discharge Medications Reconciliation Orders". This list was provided by the hospital to the agency and was faxed to the agency. Further, the record contained a "DISCHARGE PRESCRIPTION" form, from the discharging hospital. These two forms listed the patient's medications and matched with the agency "MEDICATION PROFILE", done by an RN. Additionally, the patient's POC (Plan of Care), also matched the medications listed on the RN's medication profile review. However, the record also contained an "Interagency Transfer Physician Orders", stating the patient was to take Aspirin 325 mg twice a day for one month. The Aspirin was not on the patient's POC or the agency's "MEDICATION PROFILE". The nurse who reviewed the patient's medications was interviewed. He stated he did not know the patient was to take Aspirin twice a day for one month, nor did he recall seeing the physicians order to do so. The patient stated she did not know that she was to have taken Aspirin twice a day for a month, nor did she. The patient's physician was interviewed.

He stated he had ordered the patient to take Aspirin 325 mg twice a day for a month to prevent the development of deep vein thrombosis. Additionally, three other records that were reviewed, documented the agency's medication records did not reflect with what the patient was actually taking. It was determined that the agency failed to ensure that patients' medications were fully reviewed to identify any potential medication complications for 4 of 5 sampled patients.

A deficiency was cited at G-331 and G-337 for the failure of the agency to ensure that initial comprehensive assessments had an accurate review of patient medications and had thoroughly described the patient's health care needs and how those needs were to be met.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: Physical Therapy (PT) services were not provided as ordered. The agency's Physical Therapist would not show up to appointments and when he did he did very little treatment.

Findings: One record documented a 67 year-old female who was admitted to the agency on 9/30/08, following a left total knee revision. The record contained a "Physical Therapy Assessment/Plan of Care (POC)", signed and dated by the physician on 10/6/08. The POC stated the Physical Therapist was to see the patient 2 times a week for 1 week and then 3 times a week for 2 weeks. It stated the physical therapist would provide active and passive range of motion, gait training and use and instruct the patient in the use of a Continuos Passive Motion (CPM) machine. The record contained "MISSED VISIT" sheets, dated 10/2, 10/10, 10/15 and 10/17/08. The forms stated the client declined visits because of feeling sick or not being at home at the time of the visit. Therapy visit notes dated 10/6, 10/8 and 10/13/08 documented the therapist followed the patient's POC as ordered by the physician. The patient's physician was called on 12/30/08 at 2:05 PM. He stated he was pleased with the patient's progress and had no concerns about her therapy needs. The Physical Therapist was observed giving cares in three different homes on 12/30/08. The therapist followed each patient's POC. Additionally, each patient reported they were pleased with the therapy services.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The agency's Physical Therapist caused a patient's hip to dislocate.

Findings: One record documented a 67 year-old female who was admitted to the agency on 9/30/08, following a left total knee revision. The record contained a faxed letter to the patient's physician dated 10/16/08.

The letter stated that on 10/8/08 the patient complained of "severe pain in left hip" and went to the physician's office where she received treatment. The letter also stated on 10/13/08, the patient had complained of "left hip pain" and the stomach flu and had been in contact with her physician. On 12/30/08 at 2:05 PM the patient's physician was interviewed. He stated the patient did have left hip pain but he felt it was caused by spinal issues rather then a hip joint. He stated that it would have been near to impossible for the physical therapist to have caused injury to the patient during therapies.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

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January 12, 2009

Michael Dempsey
Family Home Health
2950 East Magic View Drive, Suite 192
Meridian, Idaho 83642

RE: Family Home Health, provider #137079

Dear Mr. Dempsey:

This is to advise you of the findings of the complaint survey at Family Home Health which was concluded on December 30, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 26, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137079	A. BUILDING _____ B. WING _____	C 12/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY HOME HEALTH	2950 EAST MAGIC VIEW DR STE 192 MERIDIAN, ID 83642

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G 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your Home Health Agency. The following surveyors conducted the survey: Patrick Hendrickson R.N., H.F.S. Acronyms used in this report include: DNS = Director of Nursing mg = Milligrams POC = Plan of Care RN = Registered Nurse SOC = Start of Care	G 000	See Attached	
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by: Based on review of medical records, agency policies and staff interview, it was determined the agency failed to ensure that initial comprehensive assessments had thoroughly described the health care status needs and how those needs were being met for 1 of 5 patients (#1), whose records were reviewed. The findings included: 1. Patient #1 was a 67 year-old female who was admitted to the agency on 9/30/08, following a left total knee revision. Review of the initial comprehensive assessment, that was conducted by the registered nurse on 9/30/08, documented the following responses to listed assessment	G 331		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administration 1-15-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 331	Continued From page 1 items: a.) Patient lives with: Lives alone. b.) Primary Caregiver: No one person. c.) Ability to Dress Upper Body: Able to dress upper body without assistance if clothing is laid out or handed to the patient. d.) Ability to Dress Lower Body: Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. e.) Bathing: Able to bathe in shower or tub with the assistance of another person to get in and out of the shower or tub. f.) Transferring: Transfers with minimal human assistance or with use of an assistive devise. g.) Feeding or eating: Able to feed self independently but requires meal set up. h.) Planning and preparing light meals: Unable to prepare any light meals or reheat any delivered meals. i.) Laundry: Unable to do any laundry due to physical limitation. j.) Housekeeping: Unable to effectively participate in any housekeeping tasks. k.) Shopping: Unable to go shopping. The agency's "COMPREHENSIVE ASSESSMENT AND OASIS DATA COLLECTION; START OF CARE" policy, that was undated, stated "...gather and analyze specific data to determine the initial and continuing health care needs...". The initial comprehensive assessment did not state who would provide the above needs or how the above needs would be met. The patient was interviewed on 12/30/08, starting at 1:50 PM. She stated that she had laid in bed without being bathed or dressed for 2 weeks. She had requested additional services from the agency but said it came to the point that she had to "fire the home health" and hired another agency. She stated that the new agency had provided an aide to assist with dressing and bathing. She said the new agency also provided personal care services, and that the girl had	G 331		

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G 331	Continued From page 2 cleaned her house, washed her laundry and did light meal preparation. A "PATIENT COMPLAINT/PROBLEM RESOLUTION REPORT", dated 10/13/08, stated that on 10/14/08 the DNS wrote that the patient was upset she had not received HHA (Home Health Aide) services 2-4 hrs (Hours) per day. The nurse who did the patient's initial comprehensive assessment was interviewed on 12/30/08, starting at 8:00 AM. He stated the patient thought the agency was there to "clean her house". He said he thought the patient had a boyfriend who was bathing and dressing the patient and a 10-year-old grandson to do errands. He stated the patient did not request aide services at the time of the comprehensive assessment. However, he did not document the health care status needs of the patient and how those needs were going to be met.	G 331		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the agency failed to ensure patients' medications, including over-the-counter supplements, were reviewed to identify any potential medication complications for 4 of 5 sampled patients (#1, #2, #3, and #4) whose records were reviewed. This lack of an accurate	G 337	See attached	

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G 337	Continued From page 3 medication review could lead to potential harm to the patient in the form of drug reactions and/or adverse medication interactions. Findings include: 1. Patient #1 was a 67 year-old female who was admitted to the agency on 9/30/08, for physical therapy services following a left total knee revision. The patient's record contained a list of medications, dated 9/25/08, titled "(Hospitals name) Admission and Discharge Medications Reconciliation Orders". This list was provided by the hospital to the agency and was faxed to the agency on 9/28/08. Further, the record contained a "DISCHARGE PRESCRIPTION" form, from the discharging hospital, that was dated 9/25/08. These two forms listed the patient's medications and matched the agency "MEDICATION PROFILE", done by an RN on 9/30/08. Additionally, the patient's POC, dated 9/30/08, was also reflective of the medications listed on the RN's medication profile review. However, the record also contained an "Interagency Transfer Physician Orders", dated 9/29/08, which ordered that the patient take Aspirin 325 mg twice a day for one month. The Aspirin was not on the patient's POC or the agency's "MEDICATION PROFILE". On 12/30/08 at 8:00 AM, the nurse who reviewed the patient's medications on 9/30/08 was interviewed. He stated he did not know the patient was to take Aspirin twice a day for one month, nor did he recall seeing the physician's order to do so. On 12/30/08 at 1:50 PM, Patient #1 stated she did not know that she was to have taken Aspirin twice a day for a month.	G 337		

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G 337	Continued From page 4 On 12/30/08 at 2:05 PM, the patient's physician was interviewed. He stated he had ordered the patient was to take Aspirin 325 mg twice a day for a month to prevent the development of deep vein thrombosis. 2. Patient #2 was a 93 year-old male who was admitted to the agency on 11/14/08, for physical therapy services. The patient lived in an assisted living facility. The patient's record contained a list of medications, dated 11/13/08, titled "(Hospitals name) Admission and discharge Medications Reconciliation Orders". This list was provided by the hospital and faxed to the agency on 11/13/08. This list of medications matched the agency "MEDICATION PROFILE", done by an RN on 11/14/08. Further, the list was reflective of the listed medications on the patient's POC dated 11/14/08. These three documents stated the patient was taking Glipizide 2.5 mg each day. However, the assisted living facility's medication administration record, dated October 23-November 23, 2008, stated the patient was taking Glipizide 5 mg each day. The agency's "MEDICATION PROFILE" and POC were not consistent with what the patient was actually taking. On 12/30/08, beginning at 2:46 PM, the nurse who reviewed the patient's medications was interviewed. He could not explain the discrepancy of the patient's Glipizide dose. 3. Patient #3 was a 65 year-old female who was admitted to the agency on 1/11/08, for physical therapy and nursing services. The patient was re-certified on 11/6/08. Review of the patient's record on 12/29/08, documented the nurse had	G 337		

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G 337	Continued From page 5 last reviewed the patient's medications on 7/7/08. However, the medication profile dated 7/7/08, and the patient's POC, dated 11/16/08, listed the patient's medications as the same with no variances. On 12/30/08 at 10:54 AM, a home visit was made to the patient's residence. The patient's medications were reviewed with the patient and the following discrepancies were observed: A. The patient was taking 1000 mg of vitamin C once a day. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. B. The patient was taking 12000 to 45000 mg of Cranberry once a day as needed for treatment of urinary tract infections. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. C. The patient was taking Green Tea extract 300 mg once a day. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. D. The patient was taking L-Lysin 1000 mg once a day as needed for treatment of cold sores. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. E. The patient was taking Flaxseed Oil 1000 mg once a day. This was not listed on any medication lists, nor on the patient's POC. The	G 337		

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G 337	Continued From page 6 patient said she had been taking this medication for as long as she could remember. F. The patient was taking Calcium 1800 mg once a day. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. G. The patient was taking Lisinopril/Hctz 10/12.5 mg once a day. This was listed on the 7/7/08 medication profile and the 11/6/08 POC as "Lisinopril/Hctz 20/12.5 mg once a day." The prescription was changed on 9/3/08. H. The patient was taking Femara 2.5 mg every other day. This was listed on the 7/7/08 medication profile and the 11/6/08 POC as "Femara 2.5 mg every day." The patient stated the prescription was changed a year ago. I. The 7/7/08 medication profile and the 11/6/08 POC stated the patient was taking Oxycodone 5 mg every 6 hours. The patient did not have this medication in the home and reported she had not taken this medication for a long time. On 12/30/08, beginning at 2:46 PM, the nurse who reviewed the patient's medications on 7/7/08 and 11/06/08 was interviewed. He could not find documentation that he had reviewed the patient's medications on 11/6/08, and could not explain the discrepancy of the patient's medications on the 7/7/08 medication review and the 11/6/08's POC. He was not aware that the patient was taking the above listed medications. 4. Patient #4 was a 77 year-old female who was admitted to the agency on 12/19/08, for physical	G 337		

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G 337	Continued From page 7 therapy services following a right total knee revision. The patient's record contained a list of medications, dated 12/18/08, titled "(Hospitals name) Admission and discharge Medications Reconciliation Orders". This list was provided by the hospital and faxed to the agency on 12/18/08. This list of medications matched the agency "MEDICATION PROFILE", done by an RN on 12/19/08. On 12/30/08 at 12:29 PM, a home visit was made to the patient's residence. The patient's medications were reviewed with the patient and the patient's daughter. It was discovered the patient was taking Celebrex 200 mg twice a day. This medication was started on 12/15/08 and the patient continued to take the medication after the patient was discharged from the hospital on 12/18/08. This medication was not listed on the nurse's medication profile. On 12/30/08 at 2:46 PM, the nurse who reviewed the patient's medications was interviewed. He stated he did not know the patient was taking Celebrex 200 mg twice a day.	G 337		

Bureau of Facility Standards

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N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to Federal deficiency G 331, as it relates to the failure of the agency to ensure that initial comprehensive assessments had thoroughly described the patient's health care status needs and how those needs were being met.	N 093	See attached	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to Federal deficiency G 337, as it relates to the failure of the agency to ensure medications	N 173	See attached	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY HOME HEALTH	**2950 EAST MAGIC VIEW DR STE 192 MERIDIAN, ID 83642**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 173	Continued From page 1 were reviewed to identify any potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, or noncompliance with drug therapy.	N 173		

FAMILY HOME HEALTH
COMPLAINT SURVEY
PLAN OF CORRECTION
January 14, 2009
Prepared by: Carrie Birch, RN, Director of Clinical Services

G 331 484.55(a)(1) INITIAL ASSESSMENT VISIT
N 093 03.07024 SK. NSG. SERV.

Deficiency: Agency failed to ensure that initial comprehensive assessments had thoroughly described the health care status needs and how those needs were being met.

Plan of Correction:

- It is the responsibility of the nurse who performs the initial home health assessment, to identify the patient's need for assistance through the "Supportive Assistance" and "Life System Profile" sections of the Start of Care Assessment. If the patient requires assistance as identified in (MO380) **and** if the patient is less than independent in (MO670) thru (MO810), but refuses the services of an aide or therapist, the nurse shall document, by name, the person or persons whom the patient identifies as those who will be assisting with these activities.

Person Responsible for Implementing/Monitoring Changes/Ensure Compliance:

- Director of Clinical Services
- Clinical Coordinator
- QA Director

Date of Deficiency Correction:

- 010609 (Inservice) and monitor on an ongoing basis

G 337 484.55(c) DRUG REGIMEN REVIEW
N 173 03.07030.07 PLAN OF CARE

Deficiency: Agency failed to ensure patients' medications, including over-the-counter supplements, were reviewed to identify any potential medication complications.

Plan of Correction:

- Medication profiles shall include <u>all</u> prescribed medications, supplements, OTC and herbal remedies.
- All patient medications shall be categorized on the Medication Profile with the following key:
  - **S-** Prescriptions have been written but patient has not filled or not started
  - **T-** Medications being taken, but not prescribed by the physician
  - **O-** Medications prescribed but patient is not currently taking
  - **P-** Prescribed medications that patient is taking

- When completed by the nurse, the patient shall sign and date the Medication Profile as an indication of its completeness and accuracy.
- If the patient is opened on the weekend, the weekend nurse **and** the case manager willl sign the Medication Profile.
- All "Interagency Transfer Physician Orders" and admission orders from the MD offices shall be "noted", initialed and dated by the case manager.
- If the patient is opened on the weekend, the weekend nurse **and** the case manager will "note" the transfer order/order for admission to home health.
- The Intake Coordinator or her designee will highlight specific services/interventions and medication orders listed on the transfer/admission order.
- If the patient resides in an ALF, the nurse shall provide documentation that the MAR has been reviewed with a member of the ALF staff, at least, 1-2 times a month and more frequently if the patient is known to have a labile medical condition and/or frequent changes to his/her medication regime (i.e. DM, Anticoagulation Therapy, uncontrolled pain, CHF, etc.). If the patient is receiving primarily therapy services, it will be the responsibility of the therapist to obtain a "copy" of the MAR, at least, 1-2 times a month and more frequently if the patient is known to have a labile medical condition and/or frequent changes to his/her medication regime. The "copy" will then be reviewed by a Family Home Health nurse to ensure that medication changes are identified.

Person Responsible for Implementing/Monitoring Changes/Ensure Compliance:

- Director of Clinical Services
- Clinical Coordinator
- QA Director

Date of Deficiency Correction:

- 010609 (In-service-Case Mangers) and monitor on an ongoing basis
- 011309 (Meeting-Therapists) and monitor on an ongoing basis